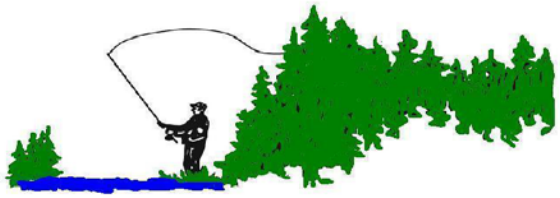

JOHN C. MATUNAS, D.D.S., P.A.

Specialist in Orthodontics

And Dentofacial Orthopedics for Children and Adults

Medical-Dental History

Patient Name: _____ Age: _____ Sex: _____
School: _____ Grade: _____
Dentist: _____ Physician: _____

The following information is essential for our office to provide orthodontic care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your orthodontic needs safely and efficiently. Incorrect information can be dangerous to your health. If you answer "yes" to any question, please give explanation.

Circle one

How would you describe patient's general health? Good Fair Poor
Has the patient been in the hospital during the past two years? Yes No
If yes, date(s) and for what reason? _____
Has patient been under the care of a medical doctor during the past two years? Yes No
If yes, who and for what reason? _____
Has patient taken any medicine or drugs during the past two years? Yes No
If yes, what medication and for what purpose(s)? _____
_____
Has patient ever had excessive bleeding requiring treatment? Yes No

Circle Yes or No for each item listed

Diabetes	Yes	No	Asthma	Yes	No
AIDS	Yes	No	Abnormal Blood Pressure	Yes	No
HIV	Yes	No	Hay Fever/Allergies	Yes	No
Heart Trouble	Yes	No	Tuberculosis	Yes	No
Rheumatic Fever	Yes	No	Prolonged Bleeding	Yes	No
Venereal Disease	Yes	No	Fainting or Dizziness	Yes	No
Seizures	Yes	No	Nervous Disorders	Yes	No
Anemia	Yes	No	Hepatitis	Yes	No
Epilepsy	Yes	No	Osteoporosis	Yes	No

Do you take Boniva, Fosamax, Reclast, or Actonel or other biophosphonates? (circle one) Yes No
Does patient have any disease, condition or problem not listed? Yes No
Is patient pregnant? Yes No
Have there been any injuries to the face, mouth, or teeth? Yes No
Does the patient have any speech problems? Yes No
Is patient a mouth breather: While awake? Yes No While asleep? Yes No
Has patient been informed of any missing or extra permanent teeth? (Circle one) Yes No

Parental permission to medicate:
Advil □ yes □ no Aspirin □ yes □ no Tylenol □ yes □ no Other:_____

Has an orthodontist been consulted previously? Yes No

Note: ANY CHANGE IN YOUR HEALTH STATUS SHOULD BE REPORTED TO OUR OFFICE IMMEDIALETY!
To the best of my knowledge, the above questions have been answered correctly.
I grant the right to the orthodontist to release health information obtained from me, and information about my orthodontic treatment to third party payers, and/or other health practitioners.
Person completing this form: Signature: _____
Print Name:_____
If signer is not the patient, indicate relationship:_____ Date:_____

I have reviewed medical history and confirm information is current and correct:
_____
Date Initials Date Initials Date Initials